

PROVIDER REQUEST FOR CHILD INFORMATION CORRECTION FORM

DECCD Mississippi Child Care Payment Program

INSTRUCTIONS

1. All requests for corrections of child information must be submitted on this form.
2. All forms must be typewritten or printed in ink.
3. Copies of all supporting documentation must be included with this form.
4. The Provider/Center Name, Provider/Center ID, mailing address, phone number must be included on the form. All incomplete forms will be returned to the provider.
5. This form must be signed by an authorized representative.
6. Burden of proof rests with the provider. If appropriate documentation cannot be supplied to support this report, no corrections will be made.
7. Use additional forms as needed.
8. Return this form to:
 DECCD
 P.O. Box 352
 Jackson, Mississippi 39202

SECTION I: PROVIDER INFORMATION

Provider/Center Name

Provider/Center ID Number:

Provider Phone Number:

Mailing Address:

City:

State:

ZIP Code:

SECTION II: CHILDREN MISSING FROM LEDGER/LIST OF AUTHORIZATIONS

Child Name:

Parent Name:

Date Care Began:

SECTION III: CHILDREN TO BE REMOVED FROM LEDGER/LIST OF AUTHORIZATIONS

Child Name:

Parent Name:

Date Care Ended:

SECTION IV: CHILDREN WITH INCORRECT REIMBURSEMENT RATES

Child Name:

Current Rate:

Corrected Rate:

SECTION V: CHILDREN WITH INCORRECT CARE STATUS (FT VS FT/PT)

Child Name:

Current Rate

Corrected Rate:

SECTION VI: OTHER CORRECTIONS NEEDED

Child Name:

Correction Request:

Signature of Authorized Representative

Date